Appendix 2
National HCFA 1500 Claim Form Completion Instructions for School Based Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Wisconsin Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Providers may also check Volume Eligibility on a monthly basis in lieu of seeing the card.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "M" in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's ten-digit identification number from the current identification card.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) from the current identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address (not required)

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid, unless the service does not require health insurance billing. Refer to the Coordination of Benefits Material in Section III of this handbook for more information.

- Leave this element blank when the provider has not billed the health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing or the recipient's identification card indicates "DEN" (dental insurance) only.

- When "Other Coverage" on the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing indicate one of the following codes in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates health insurance but it was not billed for reasons including, but not limited to: ◆ recipient denies coverage or will not cooperate; ◆ the provider knows the service in question is noncovered by the carrier; ◆ health insurance failed to respond to initial and follow-up claim; or ◆ benefits not assignable or cannot get an assignment.

- When "Other Coverage" on the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is entered on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group or FECA Number (not required)

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient has had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source (not required)

Element 17a - I.D. Number of Referring Physician (not required)

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use (not required)

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury

Enter diagnosis code S11 (which means this is a school based service) unless the recipient has a medical status code of TR. When billing covered nursing services for a recipient with a TR medical status code, indicate the appropriate tuberculosis diagnosis code in Appendix 5 of this handbook.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization (not required)

Element 24A - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same emergency indicator.

Element 24B - Place of Service

Enter place of service "0".

Element 24C - Type of Service Code

Enter the appropriate single-digit type of service code. TOS 1 should be used if you are being paid the statewide contract rate. If you are billing a district-specific cost-based rate, use TOS 9. Refer to Appendix 3 for allowable TOS codes.

Element 24D - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code. Refer to Appendix 4 of this handbook for a list of allowable procedure codes for SBS services. For durable medical equipment (DME), submit a paper claim and attach the item name, model number or description, and the invoice, receipt or cost.

Element 24E - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3 or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24F - Charges

Enter the total charge for each line. Examples: For schools using the statewide rate, multiply that rate by the number of SBS service units for each line. For schools using a district-specific rate, multiply that rate by the number of SBS service units on that line.

Element 24G - Days or Units
Enter the total number of services billed for each line. Indicate a decimal only when a fraction of a whole unit is billed. Providers should round to the nearest whole or half unit. Refer to Appendix 6 of this handbook for units of service.

Element 24H - EPSDT/Family Planning (not required)

Element 24I - EMG (not required)

Element 24J - COB (not required)

Element 24K - Reserved for Local Use (not required)

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No. (optional)
The provider may enter up to 12 characters of an internal office account number for tracking payments or other purposes. For example, a CESA may assign a different account number for each school district it bills for. This number appears on the Remittance and Status Report.

Element 27 - Accept Assignment (not required)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount paid
Enter the amount paid by the health insurance. If the health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, indicate "OI-P" in element 9.)

Element 30 - Balance Due
Enter the balance due determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered (not required)

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code and Telephone #
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.